## CHAPTER 6 — TERMINATION OF COVERAGE

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### 600 Termination of Coverage

Income Continuation Insurance (ICI) coverage for an employee who is not disabled under the ICI plan terminates on the earliest of the following events:

- Resignation
- Dismissal
- Termination
- Retirement
- Reaching age 70
- Death

The employee need not complete an *Income Continuation Insurance Application* (ET-2307) to cancel the coverage for any of the above actions. When coverage ceases, a full month's premium is required for any month or portion of a month in which earnings are paid. For example, if the employee retires on March 12 a full month's premium is due for March.

An employee disabled under the terms of the plan at the time coverage terminates will continue to be eligible to receive benefits as long as ICI Plan provisions are met, up to the maximum duration of benefits. (Refer to Reduction or Termination of Benefits in Subchapter 709.)

### 601 Lapse in Coverage

Coverage is deemed to have lapsed for any employee in active employment who fails to pay the employee portion of the premium to the employer when due. Once lapsed, coverage may only be obtained by providing evidence of insurability. An employee whose coverage lapses while on unpaid leave of absence may obtain coverage without providing evidence of insurability by reapplying within 30 days of returning to work.

## 602 Cancellation of Coverage

An employee may choose to cancel coverage at any time. However, once coverage is cancelled, the employee can only obtain coverage by providing evidence of insurability. Cancellation of coverage is effective the first day of the calendar month on or after the date the *Income Continuation Insurance Application* form canceling coverage is received by the employer. Any premium deductions taken for a coverage month after the date coverage ceases must be refunded to the employee. Premium adjustments due to a refund must be noted in the 'Premium Adjustment' columns of the *Monthly Premium Report Group Income Continuation Insurance* form (ET-1629) and these adjustments must be applied to the payment remitted to ETF.

## 603 Employer Withdrawal from the ICI Program

A participating employer may withdraw from the ICI program at the end of any calendar year provided the employer has participated in the program for a minimum of twelve months. A *Resolution to Withdraw from the Wisconsin Public Employers' Group Income Continuation Insurance Program* (ET-1322) must be received at ETF by October 1 for program termination at year's end (See Subchapter 604). Employee coverage terminates at the end of the calendar year, with the exception of those employees disabled on or before the effective date of the employer's withdrawal. Coverage for these employees ends when the ICI benefit terminates. Employers may contact the Employer Communication Center at (608) 264-7900 for additional information on withdrawal from the ICI program.

The Group Insurance Board may terminate the employer's participation in the ICI program if participation falls below the required 65%. In this event, the employer is notified by October 1 that termination will be effective at the end of that calendar year.

## 604 *Resolution to Withdraw from the Wisconsin Public Employers' Group Income Continuation Insurance Program* (ET-1322)

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

**RESOLUTION TO WITHDRAW FROM THE WISCONSIN PUBLIC EMPLOYERS' GROUP INCOME CONTINUATION INSURANCE PROGRAM**

Pursuant to the provisions of Section 2.015 (3) of the Income Continuation Insurance Plan, the _____ of _____
(Governing Body) (Employer)

resolves to withdraw from participation in the Wisconsin Public Employers Group Income Continuation Insurance Program effective January 1, _____ .
(year)

I understand that coverage will terminate for all insured participants, who are not disabled under the ICI Plan. I further understand that this Withdrawal Resolution will become effective at the end of the calendar year if the Department of Employee Trust Funds receives it by October 1 of that year.

**CERTIFICATION**

I hereby certify that this is a true, correct and complete copy of the resolution passed by the

_____ of the _____
(Governing Body) (Employer)

on the _____ day of _____, _____.
(month) (year)

_____
Employer Representative Title

_____

_____
(Address)

ETF Employer Identification Number 69-036-_____